



Affordable Care Act Questionnaire

State of Indiana

Summary Report

December 1, 2010

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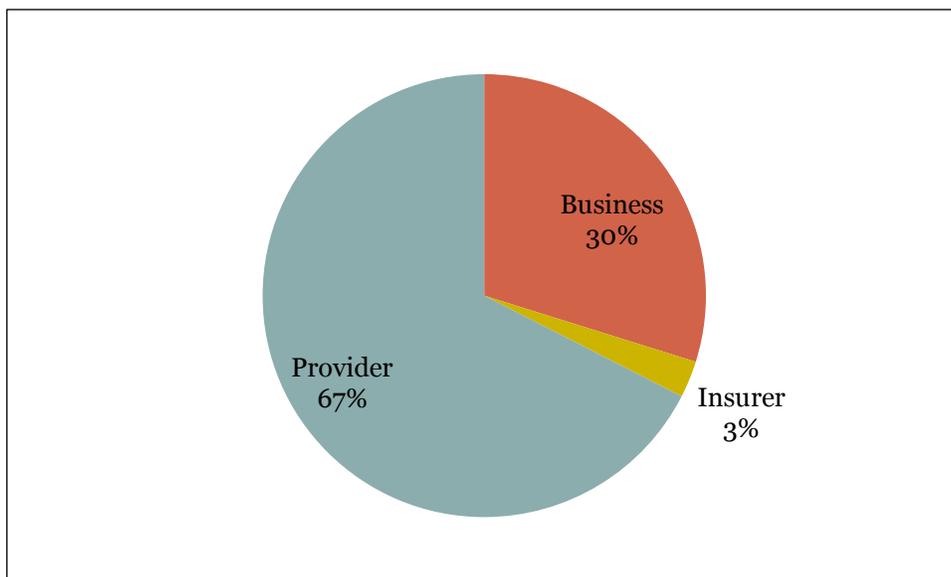
Overview

In late August 2010, the State of Indiana’s healthcare reform task force hosted three stakeholder meetings with healthcare providers, health insurers, business leaders and consumer groups to receive feedback regarding these stakeholders’ thoughts, concerns and questions regarding the Affordable Care Act (ACA) and its effects for Hoosiers. Following the meetings, the State team developed a questionnaire in order to seek additional, general feedback on the ACA. The Affordable Care Act Stakeholder Questionnaire was released by the state of Indiana September 15th and remained open until September 30th. It was available on the Nationalhealthcare.in.gov webpage and stakeholders who were invited to or attended the August meetings also received an e-mail. The Indiana Economic Development Corporation (IEDC) assisted the healthcare reform taskforce by emailing the questionnaire information and online access link to over 3,000 Hoosier businesses. Those who did not want to respond to the online questionnaire but wished to offer feedback on the ACA were provided with an e-mail address to submit their comments.

The questionnaire implemented skip logic and participants were routed on different question tracks based on their previous answers. Insurers only were asked to respond to insurer questions, providers only were asked to respond to provider questions, and businesses only were asked to respond to business questions. Questions consisted of multiple choice, 1 to 5 rating scales, fill in and comments. The questionnaire was conducted through the Survey Monkey Service, and respondents were required to provide their name and contact information. Any comments used in this report have been used with the permission of the respondent.

There were 478 responses to the questionnaire of which 409 were included in this analysis. The reasons responses were excluded include not providing a name or a valid e-mail address, responding to the questionnaire more than one time, or not providing answers or comments to any of the questions. Of the responses tallied 122 or about 30% were from businesses, 276 or about 67% were providers, and 11 or about 3% were provided by insurers.

Chart 1: Questionnaire respondents



Each group was asked different questions based on the provisions in the Affordable Care Act that that have the greatest effect on these entities. Many questions provided an area for specific comment on the issue. Responses were required to very few questions, so questions in the same categories have differing response counts.

This report is organized first to provide a look at the demographics of the insurer, provider and business questionnaire respondents. Second, all respondents were asked questions about the cost of ACA implementation to their business and costs that might result from implementation; these cost questions are discussed next for all respondent groups. All respondents were also asked questions regarding their understanding of the ACA and these responses for business, insurer, and provider respondents are discussed. Next, the track specific questions that only insurers, providers, or businesses answered are detailed by respondent category. The report finishes with sections detailing the question responses on Health Care Benefit Exchanges and the Healthy Indiana Plan (HIP). The questions on Health Care Exchanges were addressed to the Insurer and Business respondents, and the HIP questions were addressed to Insurer and Provider respondents. A conclusion of the main findings is offered at the end of the report.

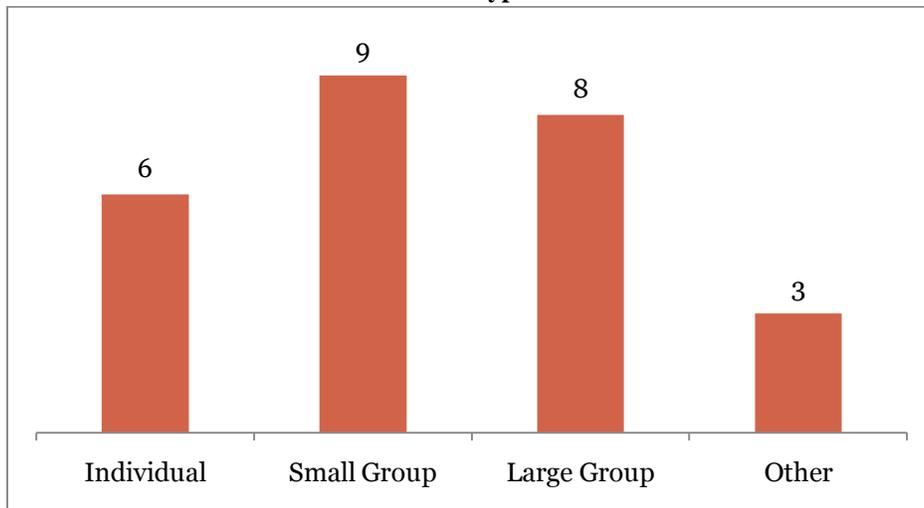
Demographics of the Respondents

All respondents were asked a series of identification questions to assist the State in understanding and analyzing of the questionnaire and how various groups felt the requirements of the legislation would affect them. The respondents represented a diverse group, and the results are analyzed by respondent group (insurer, provider, business) below:

Insurers:

Insurers were asked what type of plans they offer, an overview of the markets in which they operate and the number of lives they insure. Of the eleven insurer responses, the plans offered were well distributed. Six of the respondents offered individual plans, nine offered small group, eight offered large group, and three offered other plans. On the self reported question asking how many lives were insured by these companies showed responses from 500 lives to 2 million lives. This indicates that though only eleven responses were collected these responses captured input of both small and large companies offering a variety of coverage options in Indiana.

Chart 2: Plan Types Offered



Providers:

Providers were initially asked if they were a hospital or physician, and routed on tracks based upon this response. Physicians were asked how many full time employed physicians work in their practice, and hospitals were asked for the number of beds in their facility. Of the 276 provider responses eight were hospitals fifty-eight were other providers and the remaining 210 identified as physicians. The 226 respondents that answered practice size distribution question and this showed that 58% of respondents work in practices with ten or fewer practitioners and 42% of respondents work in practices with ten or more practitioners.

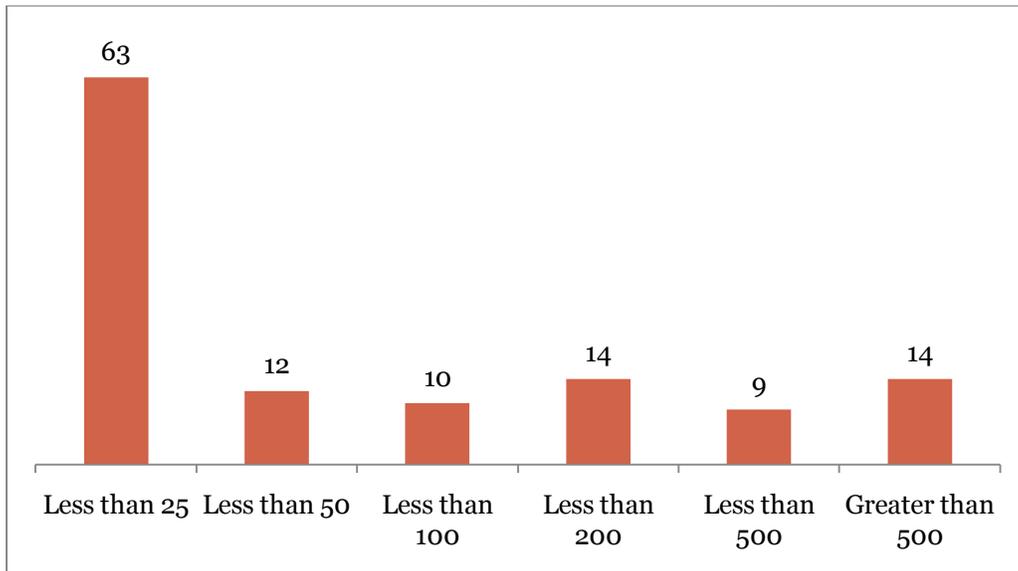
Those that identified as other providers identified as anesthesiologists, home health providers, psychologists, psychiatrists, chiropractors, social workers, nurses, nurse practitioners, community health centers, rural health centers and federally qualified health centers.

Of the 8 hospitals that responded 25% (2) had less than 50 beds, 25% (2) had between 50 and 100 beds. 12.5 % (1) had between 200 and 300 beds and 37.5% (3) had over 500 beds.

Businesses:

Businesses were asked how many employees they have at the outset of the questionnaire. Of the 122 businesses that responded, 52% (63) had fewer than 25 employees. The distribution of business size for the respondents is shown below. This represents a reasonable cross section of responses from businesses of varying sizes.

Chart 3: Number of Employees of Business respondents



Reactions to the Affordable Care Act

Following the sections of the questionnaire identifying the key characteristics of the respondent groups, each questionnaire track asked a number of questions about the respondents’ thoughts, concerns and areas lacking clarity.

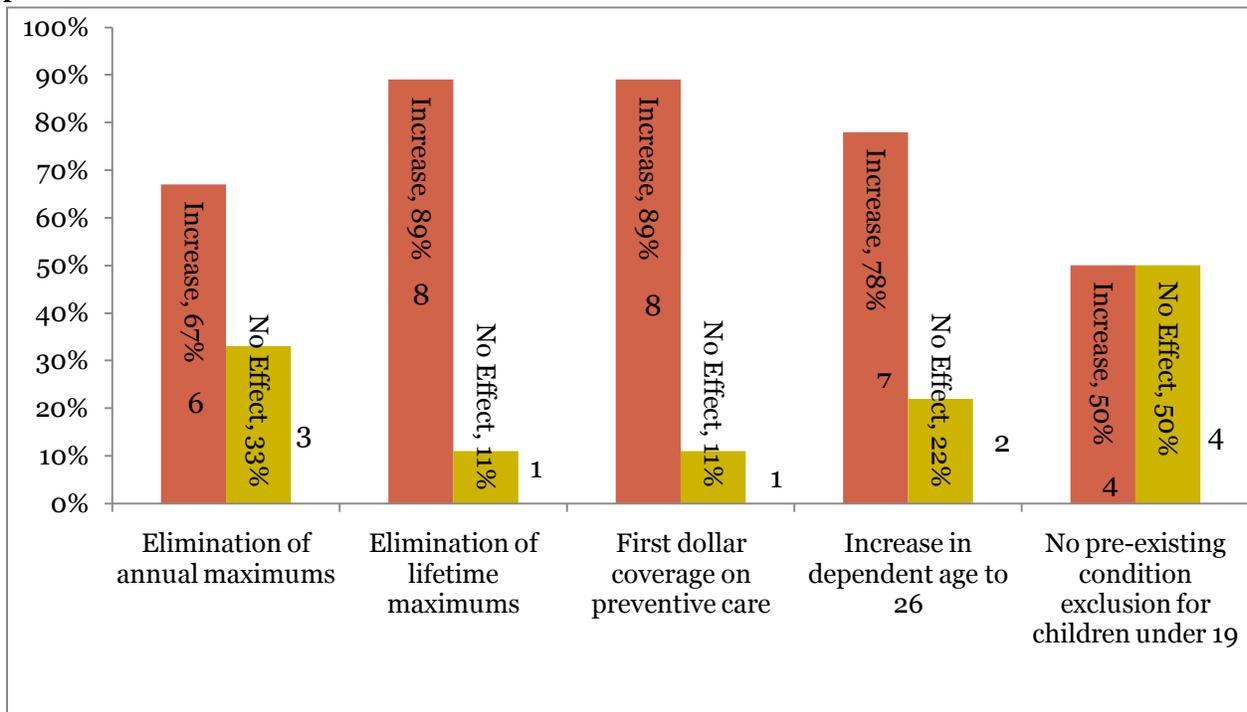
Cost:

The cost of the ACA was addressed in many places in the questionnaire. Costs specific to these stakeholder groups were addressed and insurers, businesses and providers weighed in with their thoughts and concerns.

Insurer feedback on cost questions:

Insurers were asked to estimate what the effect of various ACA provisions (elimination of annual maximums, elimination of life time maximums, increase in dependent age, first dollar coverage, and no pre-existing conditions) in the ACA would be on the products they offer to Indiana consumers. They had the option of choosing “increase premium cost,” “decrease premium cost” and “have no effect on premiums.” The below chart shows the number and percent of insurers who estimated that the aforementioned provisions would increase, decrease, or have no effect on premium costs.

Chart 10: Percent of insurers responding to the influence on premium cost of the below ACA provisions



For most provisions the majority of insurers indicated the ACA provisions would increase the cost of premiums. No respondents expected any of the provisions would decrease the cost of premiums. All other responses to these issues indicated that these provisions would have no effect on premium cost. When asked to estimate what the percent increase would be attributable to the ACA the range is from 1% to 10%. Respondents indicated that the actual increase would depend on the type of product. Some stated that a review of premium increases/decreases in relation to the ACA changes has not yet been completed. However, the overwhelming opinion of insurers is that the majority of the ACA provisions would increase the costs of providing coverage.

Business feedback on cost questions:

Businesses were asked if they would be impacted by any of the new taxes or fees in the ACA, as well as, what costs they expected to incur. Approximately 1/3 of respondents of the 95 business respondents to this question indicated that their business will be subjected to new taxes and fees in the ACA. The taxes and fees mentioned include the medical device tax, the new 1099 reporting requirement, fees for not providing healthcare coverage, tax on high cost insurance plans, general concerns about rising insurance costs and increased over all taxes as a result of the Affordable Care Act.

Businesses were asked about insurance premium increases that they have already received notice of or if they anticipate future increases. Of the 73 businesses responding to the question on premium rates 40% have already experienced premium increases since the passage of the ACA and an additional 21% have received notices of future premium increases. Eighty-nine percent (89%) of business respondents anticipate that premium rates will increase next year and 85% think that healthcare premium costs will increase under reform. When asked to self report on premium increases businesses reported from under 10% to over 100% premium increases for some tiers. Comments indicated in some cases that claims had been flat, and businesses do not know what to attribute the premium increases to accept to the new rules in the ACA. Businesses projected premium increases from 10% to 50% next year. Businesses comments show they are frustrated with these premium increases and do not feel that the Affordable Care Act will help in controlling or reducing the rates of increasing premiums.

Provider feedback on cost questions:

Providers were asked to comment on and estimate what costs they expect to incur as a result of the Affordable Care Act. This was a free form write-in question, and responses show that providers are focusing on possibility of the below ACA associated costs:

- Possible savings associated with more people having coverage
- More coverage options available to specific population segments which may provide increased reimbursement
- Increased costs of computer system upgrades
- Increased cost of employee benefits
- Increased administrative costs
- Decreasing reimbursement costs
- Costs associated with trying to implement and understand reform
- Uncertainty about being able to continue serving patients under the new legislation due to the increased associated costs.

The provider responses to this question indicated a general concern and frustration over shouldering the cost increases that are expected to occur as a result of the legislation.

Responses to the questions on costs indicate that all of these stakeholder groups are concerned about this issue. In ACA implementation it is critical that the costs which the State has control over are streamlined to the greatest extent possible.

Understanding:

Two questions that were asked to every group focused on the understanding of the Affordable Care Act. These questions were “Do you understand the Affordable Care Act?” and “Do you understand the effect the Affordable Care Act will have on your business?” The responses by these categories indicate that insurers have the best understanding of the ACA whereas businesses and providers could benefit from further outreach or education on the ACA and its provisions. The charts below and on the following page demonstrate those responses. As only 11 insurers responded to the questionnaire these responses are illustrated as both percentages and response counts.

Chart 4: Insurers: Do you understand the affordable Care Act

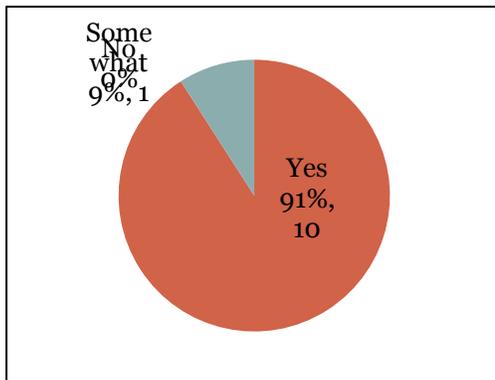


Chart 5: Insurers: Do you understand the impact the Affordable Care Act will have on your business?

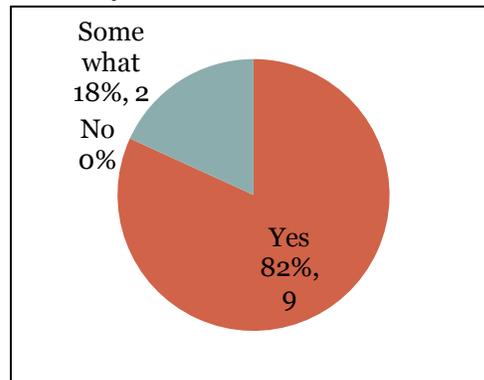


Chart 6: Businesses: Do you understand the Affordable Care Act?

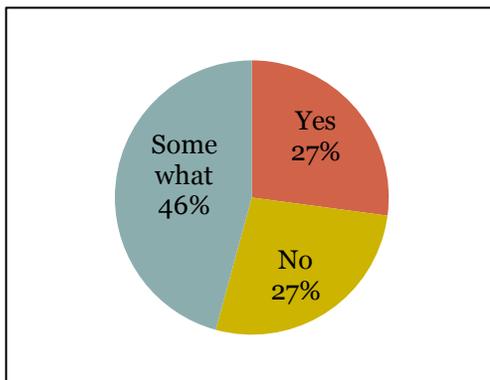


Chart 7: Businesses: Do you understand the impact the Affordable Care Act will have on your business?

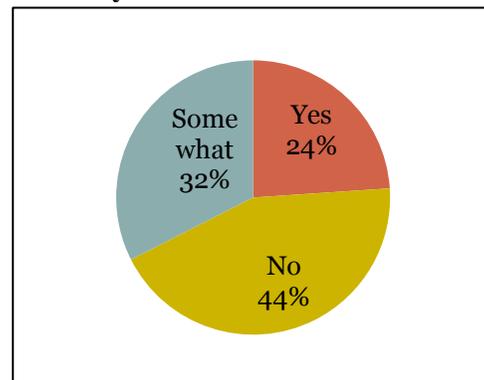


Chart 8: Providers: Do you understand the Affordable Care Act?

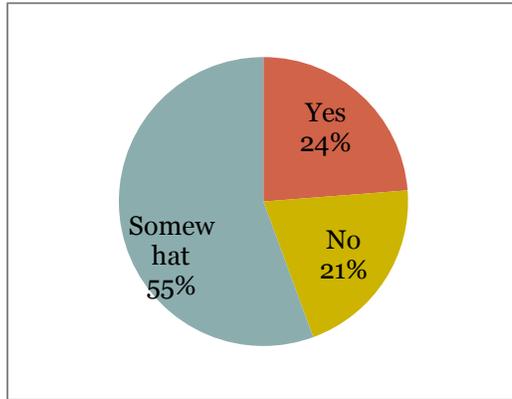
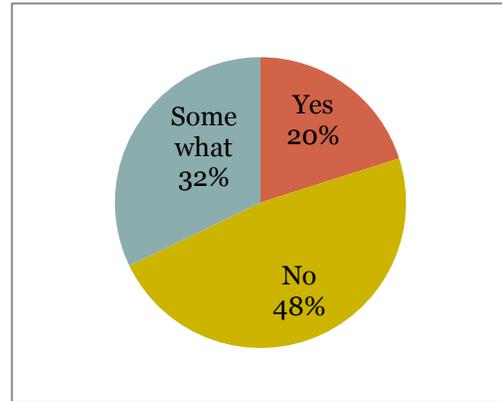


Chart 9: Providers: Do you understand the impact the Affordable Care Act will have on your business?



Many comments on understanding of the ACA expressed that the level of understanding was based solely on the available information. Nearly all who expressed understanding commented that they were awaiting additional information and regulations from the federal government. One business who indicated some understanding noted, “Although the key provisions are understood, the rulemaking process may bring additional areas to study in order to gain understanding.”

Meanwhile the majority of responses, which indicate some or no understanding of the legislation, express curiosity, frustration and/or confusion. One provider wrote, “Too many details have yet to be provided, [and there is] too much to be determined by the executive branch.” Other respondents expressed more concern over their lack of understanding. “Unfortunately, there is so little that HHS has determined or provided guidance on. We know what the impact in 2011 is, but I do not believe anyone knows after that,” another business shared. Some concerns regarding comprehension were more specific. “I attended an all day seminar that went over many of the changes that will be coming and that are currently in effect. [I] still haven’t seen what it is going to do to my costs and if I will be able to grandfather in my old health insurance policy for my employees.”

Track Specific ACA Feedback

Insurers, businesses, and providers were all asked questions specific to how the ACA would affect their businesses. The following categories summarize each of these groups responses.

Insurer Track- ACA Requirements Feedback:

Insurers were asked specifically about the effects of the ACA on the products they will offer, MLR requirements and the grandfathered plan process. There were a total of eleven insurer respondents and most of the optional insurer questions were answered by at least ten of the respondents.

When asked to estimate what the effect of the ACA would be on the products they offered, 40% (4) of insurer respondents indicated that the ACA would decrease the number of products offered, 40% (4) indicated that the ACA would have no effect on the products offered, and the remaining 20% (2) expect to offer additional products as a result of the legislation. Fifty percent (50%, 5) estimated that products they offer would change while the remaining respondents indicated that they were not certain if offered products would change (20%, 2) or had no plan to change their products as a result of the ACA (30%, 3).

Insurers were also asked to estimate what the effect of the new Medical Loss Ratio (MLR) provisions would be on the numbers of plans they offered. Fifty percent (50%, 5) of insurer respondents indicated that the MLR provisions would not affect the numbers of plans they offered. Forty percent (40%, 4) of insurers indicated that they would decrease small group plan offerings, and 20% (2) indicated that they would decrease large group plan offerings. These responses indicate that it is possible that the MLR provisions will have a moderate decreasing effect on the number of plans offered by insurance companies. Fifty percent (50%, 5) of insurer respondents were unsure if the MLR requirement that rebates be returned to enrollees would change their market focus, while 20% (2) indicated that the new MLR requirements would change their market focus. Comments on MLR showed concerns about the logistical problems of returning funds to enrollees, a need to have the final regulations defined before they can estimate the effect of MLR on their business, a need for agent commissions to be included in MLR, and some comments indicating that some insurers already meet these requirements and are expecting the new MLR provisions to have a leveling effect on the market. One insurer commented “The MLR requirement ignores the real need to have profitable years to build up reserves that can be used to cover years of higher than expected medical costs.” Several additional comments indicated that insurers, at the time, were still waiting for the regulations to be finalized and elucidated.

Insurers were also asked if they anticipate renewing current health plans that retain grandfathered status. Whether insurers would or would not renew grandfathered plans had no clear trend among respondents. Fifty percent (50%, 5) of respondents indicated that they would seek grandfathered status for plans while the other 50% (5) indicated that they would not seek grandfathered status or were not sure if they would seek this status. Comments included the difficulty of grandfathering small group plans, for example one insurer offered “For small group products it would be tremendously difficult to maintain two sets of benefit plans, some grandfathered and some not.” Also discussed was the challenges posed by the changing marketplace and grandfathered plans, and that for large group plans grandfathering will be maintained for as long as possible. Another stated, “We are concerned that there is not enough flexibility and have argued for more flexibility to help individuals who want to remain grandfathered.” Overall the comment responses highlighted concerns about how grandfathered plans will work, worries on the inability to maintain grandfather status, and confusion and administrative problems.

Provider Track- ACA Requirements Feedback:

The 276 provider respondents were asked specifically about bonus payments for primary care, Disproportionate Share (DSH) payments, tort reform, the Medicaid Expansion, general readiness of their business to cope with pent up demand and other ACA requirements and also to offer opinions on some proposed demonstration projects made available through the ACA.

In responses about the 10% bonus payment on the Medicare rate of service for primary care, 76% of primary care providers indicated that this bonus was not sufficient to keep their practice running in the new healthcare climate. One hundred percent (100%) of provider respondents are concerned that this the bonus payments on the Medicare rate of service is set to expire in 2016.

Seven out of eight hospitals that responded were concerned about the Disproportionate Share decrease that comes along with the Medicaid Expansion. Comments included that DSH is a major contributor to the bottom line and helps to compensate for low Medicaid payment rates. Concern was also expressed that people who are currently uninsured will not seek insurance under the ACA and there will still be a significant amount of uncompensated care provided.

The ACA leaves tort reform in the hands of the states. The questionnaire asked what Indiana could do to improve Tort reform. Responses indicated that Indiana’s tort reform laws are already some of the best in the nation for ensuring medical providers are protected from frivolous lawsuits. It was suggested that other states should adopt Indiana’s malpractice act. Other suggestions included placing a cap on awarded damages and holding attorneys accountable through fines or a temporary license suspension if they take up a suit and are uniformly ruled against.

Providers were asked a series of questions to about the effect of the ACA on their business and care delivery. The responses are outlined below.

Are you concerned about the potential impact of increased coverage and associated revenues on your profit margins and bad debt?	
Yes	70%
No	16%
Somewhat	14%

Do you have the operational capacity to respond to the pent-up demand from the newly-insured?	
Yes	34%
No	38%
Not Sure	28%

If reimbursement rates are drastically reduced, (for example, to the level of Medicare), could your organization sustain positive margins and replenish capital over the medium to long-term?	
Yes	8%
No	73%
Not Sure	19%

If clinical quality and effectiveness were to become the primary measures by which reimbursement levels were established and differentiated among providers, is it likely your organization would see its revenue grow?	
Yes, definitely	20%
Somewhat likely	34%

Not likely	24%
Not sure	22%

Are you concerned about the ability of the entire health system to cope with pent up demand?	
Yes	83%
No	17%

Do you think the ACA could increase inappropriate ER usage?	
Yes	79%
No	21%

Responses indicate a strong concern about the effect of the increased coverage on profit margins and bad debt and strong concern about the ability of the system to cope with the pent up demand for healthcare. Providers indicated that if reimbursement rates are reduced as a result of the legislation that they will not be able to sustain positive profit margins. There was uncertainty about their ability to cope with the increased demand for care that is expected as a result of the ACA, with the responses relatively evenly split among the possible answers. The result was similar with the question on comparative effectiveness. Interestingly, the majority of providers think the ACA could increase inappropriate ER usage. The comments indicate that some of the confusion on some of these provisions may be due to the fact that many are not yet sufficiently defined.

Out of the providers that answered, about 79% served Medicaid Patients. Of those who serve Medicaid Patients, 44% will continue to serve Medicaid patients after the expansion when 1 in 4 Hoosiers are on Medicaid, 38% were not certain if they would continue to serve Medicaid patients and 18% indicate they will not continue to serve Medicaid patients. This indicates that the expansion of Medicaid coverage may not translate to access to care for the newly insured individuals due to provider reluctance to take on these patients at the current reimbursement rate. Eighty-four percent of providers are concerned about Medicaid reimbursement under the ACA.

After each section, respondents were able to leave comments; of the 276 providers who completed the questionnaire, 138 of them commented on Medicaid, by far the largest response in the given opportunities throughout the questionnaire. Comments ranged from concern from practices who are already overwhelmed with Medicaid patients to those who expressed new concerns resulting from the ACA Medicaid expansion. No comments on Medicaid reimbursement were positive, and all expressed a level of frustration or worry about the viability of their practices. One provider wrote, “We currently aren’t taking new Medicaid patients because of rates. We just won’t dismiss patients who are already with us.” Another echoed this sentiment in writing, “Current Medicaid rates only pay 25% of our charge. We do not breakeven on Medicaid patients and could not incur an increase in Medicaid volume at these rates.” Another provider expanded on some of the contributing factors to his/her struggle with Medicaid reimbursements, “Medicaid payment doesn’t cover the costs of their care. Restrictive, complicated procedures to get approval for medicines, procedures and therapies take more and more time. Many

people are on Medicaid because they're disabled and have multiple complex problems that take much more time to treat effectively.”

Some respondents not only feared Medicaid reimbursements would remain lower, but decrease. “If they drop the rates, it will be difficult to serve the needy. Many times we do not make much profit with the Medicaid patients but choose to serve them because they need the help more than most,” commented one provider.

Meanwhile, the handful of hospitals who responded commented on diverse issues including Medicaid reimbursement. One hospital representative noted: “We are concerned about potential cuts to Medicaid DSH. Also, as noted previously, Medicaid does not fully reimburse the costs of providing care. The ACA does temporarily increase Medicaid payments for primary care physicians, but it excludes specialists who also serve that population and these higher rates are set to expire in 2014.” Another hospital respondent wrote, “Medicaid pays at what should be criminally low rates. More of the same will not be a positive. Further, unlike the Healthy Indiana Plan, Medicaid recipients have no incentive to participate in their care proactively nor requirement to share in reasonable copays, etc. This is not the fault of the consumers but the program, and serves to further entitlement behavior instead of collaborative health improvement behavior.”

Lastly, Providers were also asked to estimate the effects of some of the demonstration provisions in the ACA including Accountable Care Organizations, Comparative Effectiveness, Value-based purchasing, Medicare reimbursement changes, and Cost/Quality Ratio Payments. These estimates were provided on a 1 to 5 scale with ‘unknown’ being an option. Over one quarter of respondents indicated on every issue that its effect on their practice was unknown. On Medicare reimbursement changes and cost/quality ratio changes which the majority estimated would these provisions would have a negative effect on their business. The remaining responses were relatively equally distributed demonstrating that there is no consensus on how these proposals will affect healthcare.

Business Track- ACA Requirements Feedback:

The 122 business respondents were asked about tax credits offered to small businesses, taxes on high cost plans, to describe their current health coverage options, the effect of the ACA on their decisions to offer health coverage to their employees, the effect of the ACA on competitiveness, and about any changes they are contemplating making to their businesses as a result of the ACA. Questions were asked by business size and not all businesses answered the same set of questions.

The chart in Exhibit A (below) allowed businesses with under 25 employees to see what, if any, type of tax credit for which they might qualify. Of the 55 business respondents that have fewer than 25 employees and answered the question, “Does your business qualify for a tax credit?” 25% of them indicated that they qualified for a tax credit. An additional 20% were uncertain if they qualified or not. The self reported range of the percent tax credit these small businesses qualifies for is from 5 to 35% percent with one business reporting an expectation of receiving the maximum 35% tax credit for offering coverage.

Exhibit A: From the Commonwealth Fund: Small employer tax credits

Table 1. Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums, For-Profit Firms in 2010-2013 and Nonprofit Firms in 2014+

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Small businesses were then asked if this credit was sufficient incentive to provide healthcare to their employees. There were 48 respondents and 75% indicated that it was not sufficient incentive. Asked to comment on what would be sufficient incentive to offer health coverage comments indicated that an increased percentage credit or an increased wage limit would be helpful. Some comments indicate again general confusion over what is in the bill and what this credit means to them or a lack of understanding about the ACA. Of the 55 small business respondents 67% were unaware that the small business credits expired in 2016.

Of the all of the business respondents 71% reported that they currently offered health coverage. Of the 71% of business respondents that offer coverage 66% are planning to continue offering coverage, 3% are planning on dropping coverage, and 31% are undecided if they will continue to offer coverage.

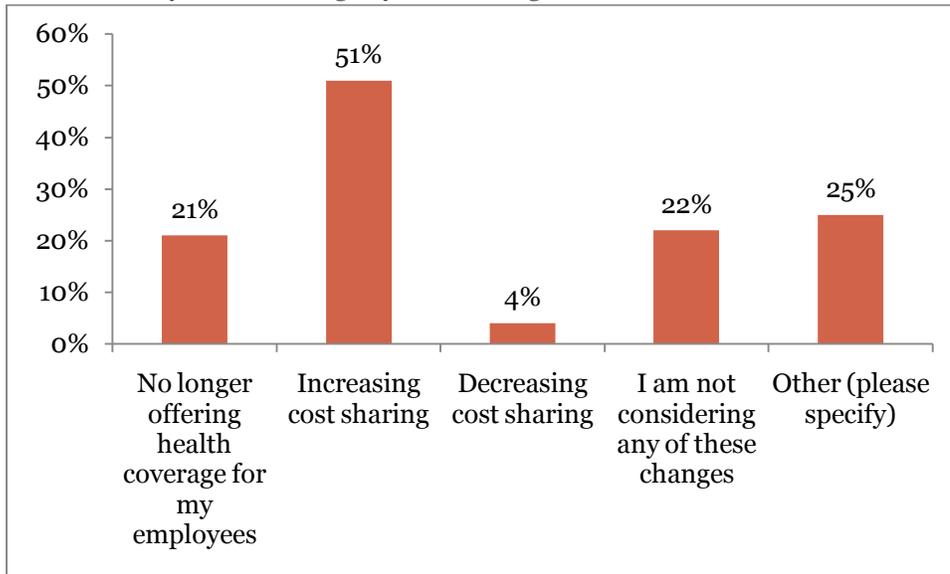
Businesses over 25 employees were asked the question in regards to their responses to the coverage penalty of \$2,000 for each uncovered employee. Seven percent (7%) indicated that they were planning on not offering coverage and paying the fine, 66% indicated they would continue to offer coverage and 27% indicated that they were not sure if they would continue to offer coverage with the penalty in place.

Of all of the business respondents that offer current healthcare coverage, 43% self-insure and 57% do not self insure. Only 9% (7) offer plans that will be affected by the tax on Cadillac plans. Of those affected by the tax on Cadillac plans 50% (3) do not know how the new tax will affect their high cost benefit plans, 17% (1) will no longer offer high cost plans, and 33% (2) are planning on continuing to offer these plans even with the new tax.

The businesses that offered high cost plans were asked if the new tax on high cost plans will be detrimental to the ability to attract desirable employees. The businesses offering these plans were split with 50% (3) answering yes and 50% (3) answering no. One third of these businesses (2) are planning on altering the plan to avoid the tax, and the remaining two thirds (4) are not sure if they will be altering the Cadillac plan or not. One comment was received on this question in regard to altering the plan and the respondent shared that cost sharing would be increased on the Cadillac plan.

Businesses that offered health coverage were asked a general question about possible changes to their health coverage plans as a result of the ACA. Overall 75% of businesses respondents reported that they are making changes to their plan as a result of the ACA. Businesses could select multiple change categories and of the 72 businesses that responded to this question 21% are considering not offering coverage, 51% are considering increasing cost sharing, 4% are considering decreasing cost sharing, 25% are considering other changes and 22% are not considering any changes. Comments on additional changes included the possibility of reducing benefit coverage, increasing employee education, introducing a high deductible plan, and eliminating employees.

Chart 11: Are you considering any of the changes below as a result of the ACA?



When asked how the ACA will influence businesses decisions on coverage 8% of business respondents indicated that the ACA would increase the chance that they will offer coverage to their employees, 20% indicated that the ACA would decrease the chance that they will offer coverage, 25% indicated that it will have no effect on their coverage decisions and 47% said that they do not know enough about the ACA to be able to estimate how it will affect their coverage decisions.

Twenty-five percent (25%) of businesses are contemplating making changes to their business as a result of the ACA. These changes include reducing the number of employees, limiting new hiring, instituting a waiting period for health coverage. There was one positive comment expressing hope that with the ACA they will now be able to offer coverage to their employees.

All businesses were also asked if the ACA would make them more competitive in the market place. Ten percent (10%) of business respondents indicated that the ACA would make them more competitive, 51%

indicated that the ACA would not help with their competitiveness in the market place, and 39 percent were not sure what the effect of the ACA would be on their market competitiveness. Comments on this question indicate that businesses are concerned overall with the costs of the ACA implementation.

An additional question also asked on if the ACA legislation would help to attract desirable employees yielded similar results. Thirteen percent (13%) of business respondents indicated that it would help them attract employees, 53% indicated that it would not help and 34% were not sure. Comments included the possibility that if some businesses drop coverage those that keep it may be able to attract more desirable employees. Other businesses were worried about losing employees or not being able to hire additional employees due to health coverage limitations.

The Exchange

The business and insurer tracks of the questionnaire posed questions about the Exchange and how they plan to interact with an Exchange and their preference for various Exchange structures and functions. Responses were different in these different groups. The following charts show how each group indicated that the Exchange be operated:

Chart 12: Insurer’s preferred Exchange governing structure

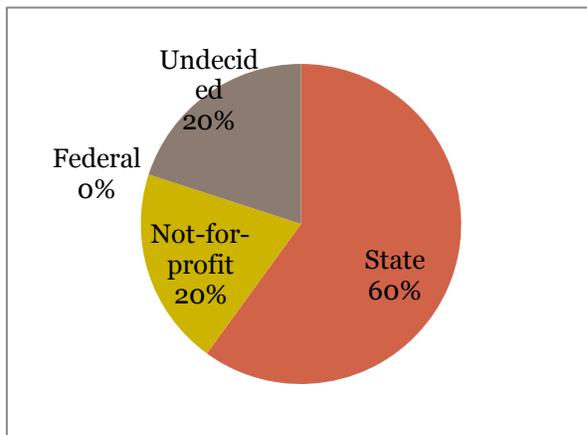
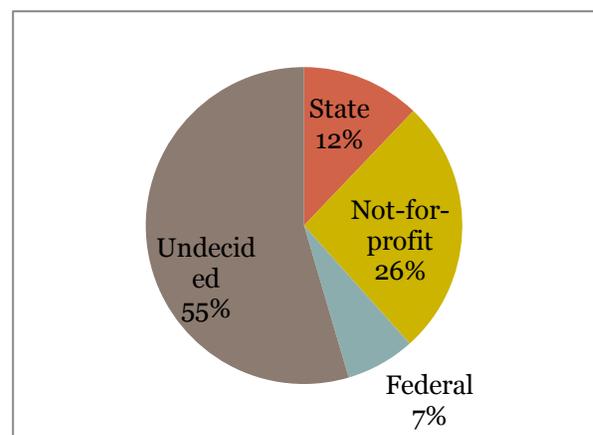


Chart 13: Businesses preferred Exchange Governing Structure

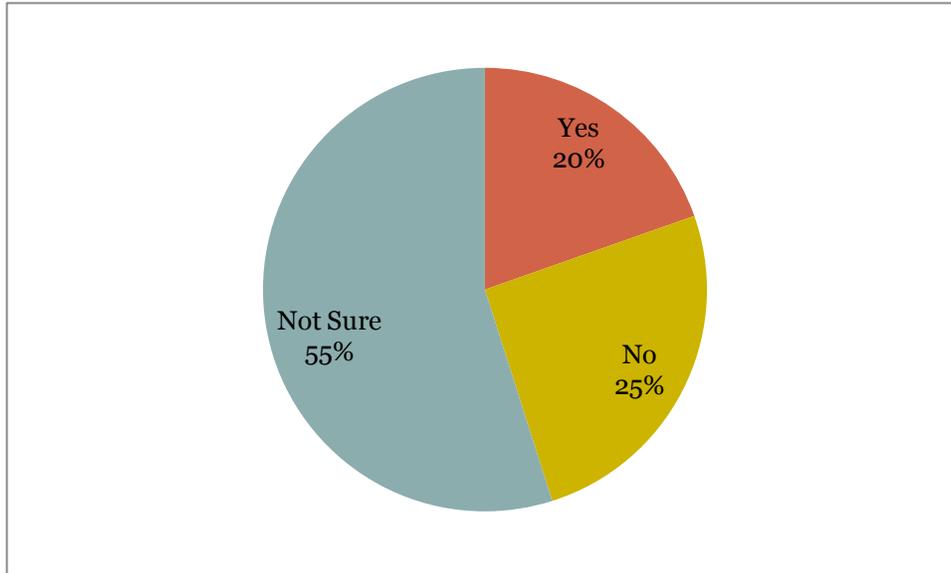


Only 7% of businesses respondents preferred a federal Exchange, and no insurers preferred a Federal Exchange. Insurers prefer a state based Exchange while businesses prefer a non-profit Exchange, or are uncertain about what type of Exchange governance system is preferable.

Businesses were also asked about their possible use of Exchanges to purchase coverage for their employees. When asked “would you be interested in purchasing insurance for your employees through an Exchange?,” fifty-nine percent (59%) of business answered ‘Not Sure’ and remaining 41% were split equally between “Yes” and “No” answers. Businesses also demonstrated uncertainty regarding defined contributions. Defined contributions would allow businesses to contribute towards a portion of their

employee’s premium and the employee could use that contribution towards the purchase of health insurance in the Exchange. The response of businesses when asked “Would you be interested in an Exchange that administered defined contribution plans?” is shown on the following page. The 55% ‘Not Sure’ response indicates that many businesses may not understand the concept or functionality of defined contribution plans.

Chart 14: Business response to interest in defined contributions.



Further Exchange questions aimed at insurers show a similar trend on some aspects of the Exchange. Insurers were asked if offering products on the Exchange would be beneficial to their company. Sixty percent (60%) answered that they were ‘Not sure’ and the remaining 40% of answers were split equally between ‘Yes’ and ‘No’.

Insurers are also split on whether Exchanges will provide consumers with better access to health insurance. Fifty percent (50%, 5) of insurers indicated that they through Exchanges would provide consumers with better access to coverage, while 40% (4) said they did not think Exchanges would improve access to health coverage and 10% (1) could were undecided on the effect of Exchanges on health coverage. Additionally insurers were unclear about what the effect of the Exchanges would be on health insurance premiums. Fifty percent (50%, 5) indicated that the effect of Exchanges on premiums was unknown, while 30% (3) indicated that Exchanges would increase premiums, and the remaining 20% (2) were equally split between the Exchange having no effect on premiums and the Exchange decreasing premiums. In another show of uncertainty, the answer of 60% (6) of insurers to the question on if they anticipate be using licensed producers for the Exchange products is ‘Unknown’; the remaining 40% (4) indicate that they do anticipate using licensed producers.

All insurers anticipate offering products outside of the Exchange. Comments indicate that insurers expect there will continue to be markets for their products outside of the Exchange.

Out of nine insurer respondents 78% (7) anticipate offering between one and ten products on the Exchange. Only one insurer estimated that they would offer no products on the Exchange, and one estimated that they would offer more than ten products on the Exchange.

A handful of comments on the Exchange were left by respondents, and they reflect a mixture of sentiments. One business wrote, “Exchanges should promote and encourage the use of IN licensed health agents to assist in selling and enrolling Hoosiers into health insurance plans.” An Indiana insurer noted, “We believe a state-administered Exchange would be most efficient and would be able to work hand-in-hand with the DOI” while another echoed the idea, “A not-for-profit Exchange might work, and would be preferable to a federally administered exchange - we have leaning towards a State Exchange, but want to see more information about Exchange operations.”

Healthy Indiana Plan (HIP)

All provider and insurer respondents were asked questions about the Healthy Indiana Plan (HIP). All insurer respondents were aware of HIP. Five insurer respondents had no-opinion when asked if they thought HIP had worked well for Indiana, three thought HIP had worked well for Indiana and only one thought the program had not worked well. When asked if they thought the HIP program should continue for Indiana Medicaid Eligibles three respondents had no opinion and six thought the program should continue. Comments indicate that insurers find the HIP benefit design to be more appropriate than a typical Medicaid design in terms of cost sharing and appropriate utilization and that they think it has been successful in covering Hoosiers. Insurers think that some of HIP’s cost sharing incentives are innovative while another comment indicates that they think the plan would be more successful if licensed insurance agents were allowed to participate.

Providers were asked similar questions about HIP. 79% of respondents were Medicaid providers (who may or may not accept HIP patients). Thirty-six percent (36%) of providers had no opinion when asked about whether they thought the HIP program worked well for Indiana. Forty-two percent (42%) of respondents thought the program had worked well for Indiana and 22% thought it had not. Forty-four percent (42%) of providers had no opinion on whether the HIP program should be continued in Indiana for Medicaid Eligibles, 44% thought HIP should be continued and 14% thought it should not be continued. Comments indicate that providers like HIP’s higher payment rates, that some worry that some of the provisions may be unattainable for patients--though many comments are supportive of making enrollees more responsible for their care, and many commented that the HIP program needs to be able to take on more enrollees and needs to enroll more specialists. Many provider comments indicated that HIP was a sound starting point and program to work from as the ACA implementation of the Medicaid expansions starts. One provider offered, “Instead of a big new healthcare plan, we should simply increase the number of patients eligible for HIP by increasing the minimum income levels to cover the working poor and lower middle class.” Another was of the opinion that “The consumer-driven nature of this program is the best chance to hold the line on public cost while providing care for eligible individuals.”

Conclusion

The responses to this questionnaire highlight the difficulty stakeholders are facing as ACA implementation goes forward. Some respondents expressed their excitement for the provisions to take effect. More commonly, many are confused about the legislation and trying to implement it where they can. However, they need more information or clarification to be able to understand the full impact of this bill on their professional situations. Some stakeholders are angry about the legislation and would even like to see it repealed. All stakeholders are concerned about the cost of this legislation to their respective businesses and industries.

Providers are concerned about the viability of their practices under the ACA and about how to cope with the expanded Medicaid population, low Medicaid reimbursement rates, and their pent up demand that they will experience in 2014 for healthcare services. Overall insurers and providers with opinions were supportive of the HIP program and supportive of continuing this program. Insurers are concerned about maintaining profitability in the light of the new regulations. Both insurers and businesses are concerned about the many new reporting requirements and the potential administrative burden. Many businesses expressed concern over being able to provide health insurance coverage to their employees, going forward.

The Exchange questions highlight that there is very little stakeholder support for a federally administered Exchange. Insurers prefer a State administered Exchange and Businesses prefer a not-for profit administered Exchange. Businesses could use more education on how a small business Exchange may work, and what provisions may help or hinder them (for example defined contributions).